SOCIAL SECURITY DISABILITY
ADULT APPLICATION PACKAGE

Do you want to know what Social Security benefits you may be currently eligible to receive? Use the Social Security Basic Eligibility Screening Tool to find out before completing these forms.

Please print and complete all forms and return them to your local Social Security Office.

To locate your Social Security office nearest you click here: Locator

- Disability Report – Adult FORM SSA-3368
- Work History Report – FORM SSA –3369
- Authorization for Source to Release Information to the Social Security Administration FORM SSA-827 (5 Copies)
- Daily Activity Questionnaire

DISABILITY REPORT - ADULT - Form SSA-3368-BK

PLEASE READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

IF YOU NEED HELP

If you need help with this form, do as much of it as you can, and your interviewer will help you finish it.

HOW TO COMPLETE THIS FORM

The information that you give us on this form will be used by the office that makes the disability decision on your disability claim. You can help them by completing as much of the form as you can.

- Please fill out as much of this form as you can before your interview appointment.
- Print or type.
- **DO NOT LEAVE ANSWERS BLANK**. If you do not know the answers, or the answer is "none" or "does not apply," please write: "don't know," or "none," or "does not apply."
- **IN SECTION 4, PUT INFORMATION ON ONLY ONE DOCTOR/HOSPITAL/CLINIC IN EACH SPACE.**
- Each address should include a ZIP code. Each telephone number should include an area code.
- **DO NOT ASK A DOCTOR OR HOSPITAL TO COMPLETE THE FORM.** However, you can get help from other people, like a freind or family member.
- If your appointment is for an interview by telephone, have the form ready to discuss with us when we call you.
- If your appointment is for an interview in our office, bring the completed form with you or mail it ahead of time, if you were told to do so.
- When a question refers to "you," "your" or the "Disabled Person," it refers to the person who is applying for disability benefits. If you are filling out the form for someone else, please provide information about him or her.
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information.
- If you need more space to answer any questions or want to tell us more about an answer, please use the "REMARKS" section on Pages 9 and 10, and show the number of the question being answered.

ABOUT YOUR MEDICAL RECORDS

If you have any medical records and copies of prescriptions at home for the person who is applying for disability benefits, send them to our office with your completed forms or bring them with you to your interview. Also, bring any prescription bottles with you. If you need the records back, tell us and we will photocopy them and return them to you.

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will do that for you. The information we ask for on this form tells us to whom we should send a request for medical and other records. If you cannot remember the names and addresses of any of the doctors or hospitals, or the dates of treatment, perhaps you can get this information from the telephone book, or from medical bills, prescriptions and prescription bottles.

WHAT WE MEAN BY "DISABILITY"

"Disability" under Social Security is based on your inability to work. For purposes of this claim, we want you to understand that "disability" means that you are unable to work as defined by the Social Security Act. You will be considered disabled if you are unable to do any kind of work for which you are suited and your disability is expected to last (or has lasted) for at least a year or to result in death. So when we ask, "when did you become unable to work," we are asking when you became disabled as defined by the Social Security Act.

The Privacy And Paperwork Reduction Acts

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d) and 1631(e)(1) of the Social Security Act. The information on this form is needed by Social Security to make a decision on the named claimant's claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named claimant's claim. Although the information you furnish is almost never used for any purpose other than making a determination about the claimant's disability, such information may be disclosed by the Social Security Administration as follows: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal Laws requiring the release of information from Social Security records (e.g., to the General Accounting Office and the Department of Veterans Affairs); and (3) to facilitate statistical research and such activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

PAPERWORK REDUCTION ACT: This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 30 minutes to read the instructions, gather the necessary facts, and answer the questions.

PLEASE REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0579

DISABILITY REPORT ADULT

For SSA Use Only
Do not write in this box.

Related SSN _____

Number Holder _____

SECTION 1- INFORMATION ABOUT THE DISABLED PERSON

A. **NAME** *(First, Middle Initial, Last)*

B. **SOCIAL SECURITY NUMBER**

C. **DAYTIME TELEPHONE NUMBER** *(If you have no number where you can be reached, give us a daytime number where we can leave a message for you.)*

_____ _____ ☐ Your Number ☐ Message Number ☐ None
Area Code *Number*

D. Give the name of a **friend or relative** that we can contact (other than your doctors) **who knows about your illnesses, injuries or conditions** and can help you with your claim.

NAME _____ RELATIONSHIP _____

ADDRESS _____
(Number, Street, Apt. No.(If any), P.O. Box, or Rural Route)

_____ DAYTIME PHONE _____ _____
City *State* *ZIP* *Area Code* *Number*

E. What is your **height** without shoes? _____ *feet* _____ *inches*

F. What is your **weight** without shoes? _____ *pounds*

G. Do you have a **medical assistance card**? (For Example, Medicaid or Medi-Cal) If "YES," show the **number** here: ☐ YES ☐ NO _____

H. Can you **speak English**? ☐ YES ☐ NO If "NO," what languages can you speak? _____

If you **cannot speak English**, is there someone we may contact who speaks English and will give you messages? *(If this is the same person as in "D" above show "SAME" here.)*

NAME _____ RELATIONSHIP _____

ADDRESS _____
(Number, Street, Apt. No.(If any), P.O. Box, or Rural Route)

_____ DAYTIME PHONE _____ _____
City *State* *ZIP* *Area Code* *Number*

I. Can you **read English**? ☐ YES ☐ NO J. Can you **write more than your name in English**? ☐ YES ☐ NO

Disability Report-Adult-Form SSA-3368-BK

SECTION 2
YOUR ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT YOU

A. What are the **illnesses, injuries or conditions** that limit your ability to work? _____

B. How do your illnesses, injuries or conditions limit your ability to work? _____

C. Do your illnesses, injuries or conditions cause you **pain**? ☐ YES ☐ NO

D. When did your illnesses, injuries or conditions **first bother you**?

Month	*Day*	*Year*

E. When did you become **unable to work** because of your illnesses, injuries or conditions?

Month	*Day*	*Year*

F. Have you **ever worked**? ☐ YES ☐ NO *(If "NO," go to Section 4.)*

G. Did you **work at any time** after the date your illnesses, injuries or conditions first bothered you? ☐ YES ☐ NO

H. If "YES," did your illnesses, injuries or conditions cause you to: *(check all that apply)*

- ☐ **work fewer hours?** *(Explain below)*
- ☐ **change your job duties?** *(Explain below)*
- ☐ **make any job-related changes such as your attendance, help needed, or employers?** *(Explain below)*

I. Are you **working now**? ☐ YES ☐ NO

If "NO," when did **you stop working**?

Month	*Day*	*Year*

J. Why did you **stop working**? _____

SECTION 3 - INFORMATION ABOUT YOUR WORK

A. List the **jobs** that you have had in the **last 15 years that you worked.**

JOB TITLE *(Example, Cook)*	TYPE OF BUSINESS *(Example, Restaurant)*	DATES WORKED *(month & year)*		HOURS PER DAY	DAYS PER WEEK	RATE OF PAY *(Per hour, day, week,month or year)*	
		From	To				
						$	
						$	
						$	
						$	
						$	
						$	
						$	

B. Describe the **job above** that you did the **longest.** (What did you do all day in this job?)

C. In **this job**, did you:

Use machines, tools or equipment?	☐ YES	☐ NO
Use technical knowledge or skills?	☐ YES	☐ NO
Do any writing, complete reports, or perform any duties like this?	☐ YES	☐ NO
Did you supervise other people?	☐ YES	☐ NO
If "YES," was this your main duty?	☐ YES	☐ NO

D. In **this job**, how many total hours each day did you:

Walk? _____
Stand? _____
Sit? _____
Climb? _____
Stoop? *(Bend down and forward at waist.)* _____
Kneel? *(Bend legs to rest on knees.)* _____
Crouch? *(Bend legs & back down & forward.)* _____
Crawl? *(Move on hands & knees.)* _____
Handle, grab or grasp big objects? _____
Write, type or handle small objects? _____

E. Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

F. Check **heaviest** weight lifted:

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs. or more ☐ Other _____

G. Check weight **frequently** lifted: *(By frequently, we mean from 1/3 to 2/3 of the workday.)*

☐ Less than 10 lbs ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs. or more ☐ Other _____

SECTION 4 - INFORMATION ABOUT YOUR MEDICAL RECORDS

A. Have you been seen by a **doctor/hospital/clinic** or anyone else for the illnesses, injuries or conditions that limit your ability to work? ☐ YES ☐ NO

B. Have you been seen by a **doctor/hospital/clinic** or anyone else for emotional or mental problems that limit your ability to work? ☐ YES ☐ NO

If you answered "NO" to both of these questions, go to Section 5.

C. List **other names** you have used on your medical records. _____

Tell us who may have medical records or other information about your illnesses, injuries or conditions.

D. **List each DOCTOR/HMO/THERAPIST.** Include your **next appointment.**

1.

NAME			DATES
STREET ADRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE _____ *Area Code* _____ *Phone Number*	**CHART/HMO #**		NEXT **APPOINTMENT**
REASONS FOR VISITS _____			
WHAT **TREATMENT** WAS RECEIVED? _____			

2.

NAME			DATES
STREET ADRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE _____ *Area Code* _____ *Phone Number*	**CHART/HMO #**		NEXT **APPOINTMENT**
REASONS FOR VISITS _____			
WHAT **TREATMENT** WAS RECEIVED? _____			

SECTION 4-INFORMATION ABOUT YOUR MEDICAL RECORDS

DOCTOR/HMO/THERAPIST

3.

NAME			DATES
STREET ADRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE Area Code / Phone Number		**CHART/HMO #**	NEXT **APPOINTMENT**
REASONS FOR VISITS			
WHAT **TREATMENT** WAS RECEIVED?			

If you need more space, use Remarks, Section 9.

E. **List each HOSPITAL/CLINIC.** Include your **next appointment.**

1.

HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
NAME			☐ **INPATIENT** STAYS *(Stayed at least overnight)*	DATE IN	DATE OUT
STREET ADDRESS					
CITY	STATE	ZIP	☐ **OUTPATIENT** VISITS *(Sent home same day)*	DATE FIRST VISIT	DATE LAST VISIT
PHONE Area Code / Phone Number			☐ **EMERGENCY ROOM** VISITS	DATE OF VISITS	

Next **appointment** _____ Your hospital/clinic **number** _____

Reasons for visits _____

What **treatment** did you receive? _____

What **doctors** do you see at this hospital/clinic on a regular basis? _____

SECTION 4-INFORMATION ABOUT YOUR MEDICAL RECORDS

HOSPITAL/CLINIC

2.

HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
NAME			☐ **INPATIENT** STAYS *(Stayed at least overnight)*	DATE IN	DATE OUT
STREET ADDRESS			☐ **OUTPATIENT** VISITS *(Sent home same day)*	DATE FIRST VISIT	DATE LAST VISIT
CITY	STATE	ZIP			
			☐ **EMERGENCY ROOM** VISITS	DATE OF VISITS	
PHONE					
Area Code	*Phone Number*				

Next **appointment** _____ Your hospital/clinic **number** _____

Reasons for visits _____

What **treatment** did you receive? _____

What **doctors** do you see at this hospital/clinic on a regular basis? _____

If you need more space, use Remarks, Section 9.

F. Does **anyone else have medical records or information** about your illnesses, injuries or conditions (Workers' Compensation, insurance companies, prisons, attorneys, welfare), or are you scheduled to see anyone else?

☐ YES *(If "YES," complete information below.)* ☐ NO

NAME			**DATES**
STREET ADRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE *Area Code* *Phone Number*			NEXT APPOINTMENT
CLAIM NUMBER (If any)			
REASONS FOR VISITS			

If you need more space, use Remarks, Section 9.

SECTION 5 - MEDICATIONS

Do you currently take any **medications** for your illnesses, injuries or conditions? ☐ YES ☐ NO

If "YES," please tell us the following: *(Look at your medicine bottles, if necessary.)*

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE

If you need more space, use Remarks, Section 9.

SECTION 6 - TESTS

Have you had, or will you have, any **medical tests** for illnesses, injuries or conditions?

☐ YES ☐ NO If "YES," please tell us the following: *(Give approximate dates, if necessary.)*

KIND OF TEST	WHEN DONE, OR WHEN WILL IT BE DONE? (Month, day, year)	WHERE DONE? (Name of Facility)	WHO SENT YOU FOR THIS TEST?
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY--Name of body part _____			
HEARING TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY--Name of body part _____			
MRI/CT SCAN Name of body part _____			

If you have had other tests, list them in Remarks, Section 9.

SECTION 7-EDUCATION/TRAINING INFORMATION

A. Check the highest grade of **school** completed.

Grade school: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED ☐

College: 1 ☐ 2 ☐ 3 ☐ 4 or more ☐

Approximate **date** completed: _____

B. Did you attend **special education** classes? ☐ YES ☐ NO *(If "NO," go to part C)*

NAME OF SCHOOL _____

ADDRESS _____

(Number, Street, Apt. No.(if any), P.O. Box or Rural Route)

_____

City *State* *Zip*

DATES ATTENDED _____ TO _____

TYPE OF PROGRAM _____

C. Have you completed any type of **special job training, trade or vocational school?**

☐ YES ☐ NO If "YES," what type? _____

Approximate date completed: _____

SECTION 8 - VOCATIONAL REHABILITATION INFORMATION

A. Have you received services from **Vocational Rehabilitation** or any other organization to help you get back to work? ☐ YES ☐ NO *(If "NO," go to part B)*

NAME OF ORGANIZATION _____

NAME OF COUNSELOR _____

ADDRESS _____

(Number, Street, Apt. No.(if any), P.O. Box or Rural Route)

_____

City *State* *Zip*

DAYTIME PHONE NUMBER _____ _____

Area Code *Number*

DATES SEEN _____ TO _____

TYPE OF SERVICES OR TESTS PERFORMED _____

(IQ, vision, physicals, hearing, workshops, etc.)

B. Would you like to receive rehabilitation services that could help you get back to work?

☐ YES ☐ NO

SECTION 9 - REMARKS

Use this section for any added information you did not show in earlier parts of the form. When you are done with this section (or if you don't have anything to add), be sure to go to the next page and complete the signature block.

SECTION 9 - REMARKS

ANYONE MAKING A FALSE STATEMENT OR REPRESENTATION OF A MATERIAL FACT FOR USE IN DETERMINING A RIGHT TO PAYMENT UNDER THE SOCIAL SECURITY ACT COMMITS A CRIME PUNISHABLE UNDER FEDERAL LAW.

Signature of **claimant** or person filing on claimant's behalf ***(parent, guardian)***	**Date** *(Month, day, year)*

Witnesses are required **ONLY** if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

1. Signature of **Witness**	2. Signature of **Witness**
Address *(Number and street, city, state, and ZIP code)*	**Address** *(Number and street, city, state, and ZIP code)*

WORK HISTORY REPORT-Form SSA-3369-BK

READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

IF YOU NEED HELP

If you need help with this form, complete as much of it as you can, and your interviewer will help you finish it.

HOW TO COMPLETE THIS FORM

The information that you give us on this form will be used by the office that makes the disability decision on your disability claim. You can help them by completing as much of the form as you can.

- Print or type.
- When a question refers to "you," "your," or "the Disabled Person," it refers to the person who is applying for disability benefits. If you are filling out the form for someone else, provide information about him or her.
- Be sure to explain an answer if the question asks for an explanation, or if you think you need to explain an answer.
- If more space is needed to answer any questions, use the "REMARKS" section on Page 8, and show the number of the question being answered.

WHY THIS INFORMATION IS IMPORTANT

The information we ask for on this form will help us understand how your illnesses or injuries or conditions might affect any work you are qualified to do. The information tells us about the kinds of work you did, including the types of skills you need and the physical and mental requirements of each job. In Section 2, be sure to give us all of the different kinds of work you have done in the last 15 years before you stopped working. There is a separate page to describe each different job.

REMEMBER TO SIGN THE FORM IN THE SIGNATURE SPACES ON PAGE 8

The Privacy and Paperwork Reduction Acts

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d) and 1631(e)(1) of the Social Security Act. The information on this form is needed by Social Security to make a decision on the named claimant's claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the name claimant's claim. Although the information you furnish is almost never used for any purpose other than making a determination about the claimant's disability, such information may be disclosed by the Social Security Administration as follows: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal Laws requiring the release of information from Social Security records (e.g., to the General Accounting Office and the Department of Veterans Affairs); and (3) to facilitate statistical research and such activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it. Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices.

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 30 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts, and fill out the form.

PLEASE REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

Form Approved
OMB No. 0960-0578

WORK HISTORY REPORT

SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

A. Name *(First, Middle Initial, Last)*	**B. SOCIAL SECURITY NUMBER**

C. **DAYTIME TELEPHONE NUMBER** *(If you have no number where you can be reached, give us a daytime number where we can leave a message for you.*

☐ Your Number ☐ Message Number ☐ None

_____ _____
Area Code *Phone Number*

SECTION 2 - INFORMATION ABOUT YOUR WORK

List the kinds of jobs that you have had in the last 15 years that you worked.

	Job Title *(Example: Cook)*	Type of Business *(Example: Restaurant)*	Dates Worked *(Month & Year)*	
			From	To
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Work History Report - Form SSA-3369-BK

Give us more information about Job No. 1 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 1

Rate of Pay $ _____ Per *(Check One)* ☐ Hour ☐ Week ☐ Month ☐ Year	Hours per day _____	Days per week _____

In this job, did you:

Use machines, tools or equipment? ☐ YES *(explain below)* ☐ NO

Use technical knowledge or skills? ☐ YES *(explain below)* ☐ NO

Write reports or complete forms? ☐ YES *(explain below)* ☐ NO

Describe this job. What did you do all day? *(If you need more space, write in the "Remarks" section.)*

In **this job**, how many total hours each day did you:

Walk? _____
Stand? _____
Sit? _____
Climb? _____
Stoop? *(Bend down and forward at waist.)* _____

Kneel? *(Bend legs to rest on knees.)* _____
Crouch? *(Bend legs & back down & forward.)* _____
Crawl? *(Move on hands & knees.)* _____
Handle, grab or grasp big objects? _____
Write, type or handle small objects? _____

Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

Check the **heaviest** weight lifted:

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs. or more ☐ Other _____

Check weight you **frequently** lifted: *(By frequently, we mean from 1/3 to 2/3 of workday.)*

☐ Less than 10 lbs ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs. or more ☐ Other _____

Did you supervise other people in this job? ☐ YES *(Complete items below.)* ☐ NO *(Skip to next page.)*

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NO

Were you a lead worker? ☐ YES ☐ NO

Give us more information about Job No. 2 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 2

Rate of Pay $ _____	Per *(Check One)* ☐ Hour ☐ Week ☐ Month ☐ Year	Hours per day _____	Days per week _____

In this job, did you:

Use machines, tools or equipment? ☐ YES *(explain below)* ☐ NO

Use technical knowledge or skills? ☐ YES *(explain below)* ☐ NO

Write reports or complete forms? ☐ YES *(explain below)* ☐ NO

Describe this job. What did you do all day? *(If you need more space, write in the"Remarks" section.)*

In **this job**, how many total hours each day did you:

Walk? _____
Stand? _____
Sit? _____
Climb? _____
Stoop? *(Bend down and forward at waist.)* _____

Kneel? *(Bend legs to rest on knees.)* _____
Crouch? *(Bend legs & back down & forward.)* _____
Crawl? *(Move on hands & knees.)* _____
Handle, grab or grasp big objects? _____
Write, type or handle small objects? _____

Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

Check the **heaviest** weight lifted:

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs. or more ☐ Other _____

Check weight you **frequently** lifted: *(By frequently, we mean from 1/3 to 2/3 of workday.)*

☐ Less than 10 lbs ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs. or more ☐ Other _____

Did you supervise other people in this job? ☐ YES *(Complete items below.)* ☐ NO *(Skip to next page.)*

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NO

Were you a lead worker? ☐ YES ☐ NO

Give us more information about Job No. 3 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 3

Rate of Pay $ _____	Per *(Check One)* ☐ Hour ☐ Week ☐ Month ☐ Year	Hours per day _____	Days per week _____

In this job, did you:

Use machines, tools or equipment? ☐ YES *(explain below)* ☐ NO

Use technical knowledge or skills? ☐ YES *(explain below)* ☐ NO

Write reports or complete forms? ☐ YES *(explain below)* ☐ NO

Describe this job. What did you do all day? *(If you need more space, write in the "Remarks" section.)*

In **this job**, how many total hours each day did you:

Walk? _____
Stand? _____
Sit? _____
Climb? _____
Stoop? *(Bend down and forward at waist.)* _____

Kneel? *(Bend legs to rest on knees.)* _____
Crouch? *(Bend legs & back down & forward.)* _____
Crawl? *(Move on hands & knees.)* _____
Handle, grab or grasp big objects? _____
Write, type or handle small objects? _____

Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

Check the **heaviest** weight lifted:

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs. or more ☐ Other _____

Check weight you **frequently** lifted: *(By frequently, we mean from 1/3 to 2/3 of workday.)*

☐ Less than 10 lbs ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs. or more ☐ Other _____

Did you supervise other people in this job? ☐ YES *(Complete items below.)* ☐ NO *(Skip to next page.)*

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NO

Were you a lead worker? ☐ YES ☐ NO

Give us more information about Job No. 4 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 4

Rate of Pay $ _____	Per *(Check One)* ☐ Hour ☐ Week ☐ Month ☐ Year	Hours per day _____	Days per week _____

In this job, did you:

Use machines, tools or equipment? ☐ YES *(explain below)* ☐ NO

Use technical knowledge or skills? ☐ YES *(explain below)* ☐ NO

Write reports or complete forms? ☐ YES *(explain below)* ☐ NO

Describe this job. What did you do all day? *(If you need more space, write in the"Remarks" section.)*

In **this job**, how many total hours each day did you:

Walk? _____
Stand? _____
Sit? _____
Climb? _____
Stoop? *(Bend down and forward at waist.)* _____

Kneel? *(Bend legs to rest on knees.)* _____
Crouch? *(Bend legs & back down & forward.)* _____
Crawl? *(Move on hands & knees.)* _____
Handle, grab or grasp big objects? _____
Write, type or handle small objects? _____

Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

Check the **heaviest** weight lifted:

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs. or more ☐ Other _____

Check weight you **frequently** lifted: *(By frequently, we mean from 1/3 to 2/3 of workday.)*

☐ Less than 10 lbs ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs. or more ☐ Other _____

Did you supervise other people in this job? ☐ YES *(Complete items below.)* ☐ NO *(Skip to next page.)*

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NO

Were you a lead worker? ☐ YES ☐ NO

Give us more information about Job No. 5 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 5

Rate of Pay $ _____	Per *(Check One)* ☐ Hour ☐ Week ☐ Month ☐ Year	Hours per day _____	Days per week _____

In this job, did you:

Use machines, tools or equipment? ☐ YES *(explain below)* ☐ NO

Use technical knowledge or skills? ☐ YES *(explain below)* ☐ NO

Write reports or complete forms? ☐ YES *(explain below)* ☐ NO

Describe this job. What did you do all day? *(If you need more space, write in the "Remarks" section.)*

In **this job**, how many total hours each day did you:

Walk? _____
Stand? _____
Sit? _____
Climb? _____
Stoop? *(Bend down and forward at waist.)* _____

Kneel? *(Bend legs to rest on knees.)* _____
Crouch? *(Bend legs & back down & forward.)* _____
Crawl? *(Move on hands & knees.)* _____
Handle, grab or grasp big objects? _____
Write, type or handle small objects? _____

Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

Check the **heaviest** weight lifted:

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs. or more ☐ Other _____

Check weight you **frequently** lifted: *(By frequently, we mean from 1/3 to 2/3 of workday.)*

☐ Less than 10 lbs ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs. or more ☐ Other _____

Did you supervise other people in this job? ☐ YES *(Complete items below.)* ☐ NO *(Skip to next page.)*

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NO

Were you a lead worker? ☐ YES ☐ NO

Give us more information about Job No. 6 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 6

Rate of Pay $ _____	Per *(Check One)* ☐ Hour ☐ Week ☐ Month ☐ Year	Hours per day _____	Days per week _____

In this job, did you:

Use machines, tools or equipment? ☐ YES *(explain below)* ☐ NO

Use technical knowledge or skills? ☐ YES *(explain below)* ☐ NO

Write reports or complete forms? ☐ YES *(explain below)* ☐ NO

Describe this job. What did you do all day? *(If you need more space, write in the "Remarks" section.)*

In **this job**, how many total hours each day did you:

Walk? _____
Stand? _____
Sit? _____
Climb? _____
Stoop? *(Bend down and forward at waist.)* _____

Kneel? *(Bend legs to rest on knees.)* _____
Crouch? *(Bend legs & back down & forward.)* _____
Crawl? *(Move on hands & knees.)* _____
Handle, grab or grasp big objects? _____
Write, type or handle small objects? _____

Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

Check the **heaviest** weight lifted:

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs. or more ☐ Other _____

Check weight you **frequently** lifted: *(By frequently, we mean from 1/3 to 2/3 of workday.)*

☐ Less than 10 lbs ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs. or more ☐ Other _____

Did you supervise other people in this job? ☐ YES *(Complete items below.)* ☐ NO *(Skip to next page.)*

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NO

Were you a lead worker? ☐ YES ☐ NO

SECTION 3 - REMARKS

ANYONE MAKING A FALSE STATEMENT OR REPRESENTATION OF A MATERIAL FACT FOR USE IN DETERMINING A RIGHT TO PAYMENT UNDER THE SOCIAL SECURITY ACT COMMITS A CRIME PUNISHABLE UNDER FEDERAL LAW.

Signature of **claimant** or person filing on claimant's behalf *(parent, guardian)*	**Date** *(Month, day, year)*

Witnesses are required **ONLY** if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

1. Signature of **Witness**	2. Signature of **Witness**
Address *(Number and street, city, state, and ZIP code)*	**Address** *(Number and street, city, state, and ZIP code)*

RESIDENTS OF IOWA

I understand that according to Iowa Code CH 228 that I may review the disclosed information by contacting the agency or individual releasing the information. I understand that I have a right to a copy of this Form-827

_____ Yes, I want a copy

_____ No, I do not want a copy

TO BE COMPLETED BY SSA

NUMBER HOLDER

SOCIAL SECURITY NUMBER

EMPLOYEE/CLAIMANT/BENEFICIARY *(If other than Number Holder)*

AUTHORIZATION FOR SOURCE TO RELEASE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

INFORMATION ABOUT MEDICAL OR OTHER SOURCE-PLEASE PRINT, TYPE, OR WRITE CLEARLY

NAME AND ADDRESS OF SOURCE *(Include Zip Code)*	RELATIONSHIP TO DISABLED PERSON
,	

INFORMATION ABOUT DISABLED PERSON-PLEASE PRINT, TYPE, OR WRITE CLEARLY

NAME AND ADDRESS *(If known)* AT TIME DISABLED PERSON HAD CONTACT WITH SOURCE *(Include Zip Code)*	DATE OF BIRTH	DISABLED PERSON'S I.D. NUMBER *(If known and different than SSN) (Clinic/Patient No.)*
,		

APPROXIMATE DATES OF DISABLED PERSON'S CONTACT WITH SOURCE *(e.g., dates of hospital admission, treatment, discharge, etc.)*

TO BE COMPLETED BY DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF

GENERAL AND SPECIAL AUTHORIZATION TO RELEASE MEDICAL AND OTHER INFORMATION IN ACCORDANCE WITH THE PROVISIONS OF THE SOCIAL SECURITY ACT; THE PUBLIC HEALTH SERVICE ACT, SECTIONS 523 AND 527; AND TITLE 38 U.S.C. VETERANS BENEFITS, SECTION 4132.

I hereby authorize the above-named source to release or disclose to the Social Security Administration or State agency the following information for the period(s) identified above:

1) All medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my impairment(s), including psychological or psychiatric impairment(s), drug abuse, alcoholism, sickle cell anemia, human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome (AIDS) or tests for HIV), or sexually transmitted diseases;
2) Information about how my impairment(s) affects my ability to complete tasks and activities of daily living;
3) Information about how my impairment(s) affected my ability to work.

I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above.

I understand that this authorization, except for action already taken, may be voided by me at anytime. If I do not void this authorization, it will automatically end when a final decision is made on my claim. If I am already receiving benefits, the authorization will end when a final decision is made as to whether I can continue to receive benefits.

READ IMPORTANT INFORMATION ON REVERSE BEFORE SIGNING FORM BELOW.

SIGNATURE OF DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF	RELATIONSHIP TO DISABLED PERSON (If other than self)	DATE
STREET ADDRESS		TELEPHONE NUMBER (Area Code)
CITY	STATE	ZIP CODE

The signature and address of a person who either knows the person signing this form or is satisfied as to that person's identity is requested below. This is not required by the Social Security Administration, but without it the source may not honor this authorization.

SIGNATURE OF WITNESS	STREET ADDRESS	
CITY	STATE	ZIP CODE

RESIDENTS OF IOWA

I understand that according to Iowa Code CH 228 that I may review the disclosed information by contacting the agency or individual releasing the information. I understand that I have a right to a copy of this Form-827

_____ Yes, I want a copy

_____ No, I do not want a copy

TO BE COMPLETED BY SSA

NUMBER HOLDER

SOCIAL SECURITY NUMBER

EMPLOYEE/CLAIMANT/BENEFICIARY *(If other than Number Holder)*

AUTHORIZATION FOR SOURCE TO RELEASE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

INFORMATION ABOUT MEDICAL OR OTHER SOURCE-PLEASE PRINT, TYPE, OR WRITE CLEARLY

NAME AND ADDRESS OF SOURCE *(Include Zip Code)*	RELATIONSHIP TO DISABLED PERSON
,	

INFORMATION ABOUT DISABLED PERSON-PLEASE PRINT, TYPE, OR WRITE CLEARLY

NAME AND ADDRESS *(If known)* AT TIME DISABLED PERSON HAD CONTACT WITH SOURCE *(Include Zip Code)*	DATE OF BIRTH	DISABLED PERSON'S I.D. NUMBER *(If known and different than SSN) (Clinic/Patient No.)*
,		

APPROXIMATE DATES OF DISABLED PERSON'S CONTACT WITH SOURCE *(e.g., dates of hospital admission, treatment, discharge, etc.)*

TO BE COMPLETED BY DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF

GENERAL AND SPECIAL AUTHORIZATION TO RELEASE MEDICAL AND OTHER INFORMATION IN ACCORDANCE WITH THE PROVISIONS OF THE SOCIAL SECURITY ACT; THE PUBLIC HEALTH SERVICE ACT, SECTIONS 523 AND 527; AND TITLE 38 U.S.C. VETERANS BENEFITS, SECTION 4132.

I hereby authorize the above-named source to release or disclose to the Social Security Administration or State agency the following information for the period(s) identified above:

1) All medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my impairment(s), including psychological or psychiatric impairment(s), drug abuse, alcoholism, sickle cell anemia, human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome (AIDS) or tests for HIV), or sexually transmitted diseases;
2) Information about how my impairment(s) affects my ability to complete tasks and activities of daily living;
3) Information about how my impairment(s) affected my ability to work.

I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above.

I understand that this authorization, except for action already taken, may be voided by me at anytime. If I do not void this authorization, it will automatically end when a final decision is made on my claim. If I am already receiving benefits, the authorization will end when a final decision is made as to whether I can continue to receive benefits.

READ IMPORTANT INFORMATION ON REVERSE BEFORE SIGNING FORM BELOW.

SIGNATURE OF DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF	RELATIONSHIP TO DISABLED PERSON (If other than self)	DATE
STREET ADDRESS		TELEPHONE NUMBER (Area Code)
CITY	STATE	ZIP CODE

The signature and address of a person who either knows the person signing this form or is satisfied as to that person's identity is requested below. This is not required by the Social Security Administration, but without it the source may not honor this authorization.

SIGNATURE OF WITNESS	STREET ADDRESS	
CITY	STATE	ZIP CODE

RESIDENTS OF IOWA

I understand that according to Iowa Code CH 228 that I may review the disclosed information by contacting the agency or individual releasing the information. I understand that I have a right to a copy of this Form-827

_____ Yes, I want a copy

_____ No, I do not want a copy

TO BE COMPLETED BY SSA

NUMBER HOLDER

SOCIAL SECURITY NUMBER

EMPLOYEE/CLAIMANT/BENEFICIARY *(If other than Number Holder)*

AUTHORIZATION FOR SOURCE TO RELEASE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

INFORMATION ABOUT MEDICAL OR OTHER SOURCE-PLEASE PRINT, TYPE, OR WRITE CLEARLY

NAME AND ADDRESS OF SOURCE *(Include Zip Code)*	RELATIONSHIP TO DISABLED PERSON
,	

INFORMATION ABOUT DISABLED PERSON-PLEASE PRINT, TYPE, OR WRITE CLEARLY

NAME AND ADDRESS *(If known)* AT TIME DISABLED PERSON HAD CONTACT WITH SOURCE *(Include Zip Code)*	DATE OF BIRTH	DISABLED PERSON'S I.D. NUMBER *(If known and different than SSN) (Clinic/Patient No.)*
,		

APPROXIMATE DATES OF DISABLED PERSON'S CONTACT WITH SOURCE *(e.g., dates of hospital admission, treatment, discharge, etc.)*

TO BE COMPLETED BY DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF

GENERAL AND SPECIAL AUTHORIZATION TO RELEASE MEDICAL AND OTHER INFORMATION IN ACCORDANCE WITH THE PROVISIONS OF THE SOCIAL SECURITY ACT; THE PUBLIC HEALTH SERVICE ACT, SECTIONS 523 AND 527; AND TITLE 38 U.S.C. VETERANS BENEFITS, SECTION 4132.

I hereby authorize the above-named source to release or disclose to the Social Security Administration or State agency the following information for the period(s) identified above:

1) All medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my impairment(s), including psychological or psychiatric impairment(s), drug abuse, alcoholism, sickle cell anemia, human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome (AIDS) or tests for HIV), or sexually transmitted diseases;
2) Information about how my impairment(s) affects my ability to complete tasks and activities of daily living;
3) Information about how my impairment(s) affected my ability to work.

I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above.

I understand that this authorization, except for action already taken, may be voided by me at anytime. If I do not void this authorization, it will automatically end when a final decision is made on my claim. If I am already receiving benefits, the authorization will end when a final decision is made as to whether I can continue to receive benefits.

READ IMPORTANT INFORMATION ON REVERSE BEFORE SIGNING FORM BELOW.

SIGNATURE OF DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF	RELATIONSHIP TO DISABLED PERSON (If other than self)	DATE
STREET ADDRESS		TELEPHONE NUMBER (Area Code)
CITY	STATE	ZIP CODE

The signature and address of a person who either knows the person signing this form or is satisfied as to that person's identity is requested below. This is not required by the Social Security Administration, but without it the source may not honor this authorization.

SIGNATURE OF WITNESS	STREET ADDRESS	
CITY	STATE	ZIP CODE

RESIDENTS OF IOWA

I understand that according to Iowa Code CH 228 that I may review the disclosed information by contacting the agency or individual releasing the information. I understand that I have a right to a copy of this Form-827

_____ Yes, I want a copy

_____ No, I do not want a copy

TO BE COMPLETED BY SSA

NUMBER HOLDER

SOCIAL SECURITY NUMBER

EMPLOYEE/CLAIMANT/BENEFICIARY *(If other than Number Holder)*

AUTHORIZATION FOR SOURCE TO RELEASE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

INFORMATION ABOUT MEDICAL OR OTHER SOURCE-PLEASE PRINT, TYPE, OR WRITE CLEARLY

NAME AND ADDRESS OF SOURCE *(Include Zip Code)*	RELATIONSHIP TO DISABLED PERSON
,	

INFORMATION ABOUT DISABLED PERSON-PLEASE PRINT, TYPE, OR WRITE CLEARLY

NAME AND ADDRESS *(If known)* AT TIME DISABLED PERSON HAD CONTACT WITH SOURCE *(Include Zip Code)*	DATE OF BIRTH	DISABLED PERSON'S I.D. NUMBER *(If known and different than SSN) (Clinic/Patient No.)*
,		

APPROXIMATE DATES OF DISABLED PERSON'S CONTACT WITH SOURCE *(e.g., dates of hospital admission, treatment, discharge, etc.)*

TO BE COMPLETED BY DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF

GENERAL AND SPECIAL AUTHORIZATION TO RELEASE MEDICAL AND OTHER INFORMATION IN ACCORDANCE WITH THE PROVISIONS OF THE SOCIAL SECURITY ACT; THE PUBLIC HEALTH SERVICE ACT, SECTIONS 523 AND 527; AND TITLE 38 U.S.C. VETERANS BENEFITS, SECTION 4132.

I hereby authorize the above-named source to release or disclose to the Social Security Administration or State agency the following information for the period(s) identified above:

1) All medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my impairment(s), including psychological or psychiatric impairment(s), drug abuse, alcoholism, sickle cell anemia, human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome (AIDS) or tests for HIV), or sexually transmitted diseases;
2) Information about how my impairment(s) affects my ability to complete tasks and activities of daily living;
3) Information about how my impairment(s) affected my ability to work.

I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above.

I understand that this authorization, except for action already taken, may be voided by me at anytime. If I do not void this authorization, it will automatically end when a final decision is made on my claim. If I am already receiving benefits, the authorization will end when a final decision is made as to whether I can continue to receive benefits.

READ IMPORTANT INFORMATION ON REVERSE BEFORE SIGNING FORM BELOW.

SIGNATURE OF DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF	RELATIONSHIP TO DISABLED PERSON (If other than self)	DATE
STREET ADDRESS		TELEPHONE NUMBER (Area Code)
CITY	STATE	ZIP CODE

The signature and address of a person who either knows the person signing this form or is satisfied as to that person's identity is requested below. This is not required by the Social Security Administration, but without it the source may not honor this authorization.

SIGNATURE OF WITNESS	STREET ADDRESS	
CITY	STATE	ZIP CODE

RESIDENTS OF IOWA

I understand that according to Iowa Code CH 228 that I may review the disclosed information by contacting the agency or individual releasing the information. I understand that I have a right to a copy of this Form-827

_____ Yes, I want a copy

_____ No, I do not want a copy

TO BE COMPLETED BY SSA

NUMBER HOLDER

SOCIAL SECURITY NUMBER

EMPLOYEE/CLAIMANT/BENEFICIARY *(If other than Number Holder)*

AUTHORIZATION FOR SOURCE TO RELEASE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

INFORMATION ABOUT MEDICAL OR OTHER SOURCE-PLEASE PRINT, TYPE, OR WRITE CLEARLY

NAME AND ADDRESS OF SOURCE *(Include Zip Code)*	RELATIONSHIP TO DISABLED PERSON
,	

INFORMATION ABOUT DISABLED PERSON-PLEASE PRINT, TYPE, OR WRITE CLEARLY

NAME AND ADDRESS *(If known)* AT TIME DISABLED PERSON HAD CONTACT WITH SOURCE *(Include Zip Code)*	DATE OF BIRTH	DISABLED PERSON'S I.D. NUMBER *(If known and different than SSN) (Clinic/Patient No.)*
,		

APPROXIMATE DATES OF DISABLED PERSON'S CONTACT WITH SOURCE *(e.g., dates of hospital admission, treatment, discharge, etc.)*

TO BE COMPLETED BY DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF

GENERAL AND SPECIAL AUTHORIZATION TO RELEASE MEDICAL AND OTHER INFORMATION IN ACCORDANCE WITH THE PROVISIONS OF THE SOCIAL SECURITY ACT; THE PUBLIC HEALTH SERVICE ACT, SECTIONS 523 AND 527; AND TITLE 38 U.S.C. VETERANS BENEFITS, SECTION 4132.

I hereby authorize the above-named source to release or disclose to the Social Security Administration or State agency the following information for the period(s) identified above:

1) All medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my impairment(s), including psychological or psychiatric impairment(s), drug abuse, alcoholism, sickle cell anemia, human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome (AIDS) or tests for HIV), or sexually transmitted diseases;
2) Information about how my impairment(s) affects my ability to complete tasks and activities of daily living;
3) Information about how my impairment(s) affected my ability to work.

I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above.

I understand that this authorization, except for action already taken, may be voided by me at anytime. If I do not void this authorization, it will automatically end when a final decision is made on my claim. If I am already receiving benefits, the authorization will end when a final decision is made as to whether I can continue to receive benefits.

READ IMPORTANT INFORMATION ON REVERSE BEFORE SIGNING FORM BELOW.

SIGNATURE OF DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF	RELATIONSHIP TO DISABLED PERSON (If other than self)	DATE
STREET ADDRESS		TELEPHONE NUMBER (Area Code)
CITY	STATE	ZIP CODE

The signature and address of a person who either knows the person signing this form or is satisfied as to that person's identity is requested below. This is not required by the Social Security Administration, but without it the source may not honor this authorization.

SIGNATURE OF WITNESS	STREET ADDRESS	
CITY	STATE	ZIP CODE

Explanation of Form SSA-827-OP2, Authorization For Source to Release Information to the Social Security Administration (SSA)

We are requesting that you authorize the release of information about your impairment to us. Sources usually require this authorization before releasing information to us. Also, the law requires this authorization for release of information about certain conditions.

You can provide this authorization by signing a Form SSA-827-OP2, Authorization For Source to Release Information to the Social Security Administration (SSA), for each source identified during your disability interview or during the processing of your claim. We must inform you that because of various Federal disclosure laws, SSA cannot give an absolute pledge of confidentiality regarding information submitted in connection with your claim.

PRIVACY ACT NOTICE

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d) and 1631(e)(1) of the Social Security Act. The information on this form is needed by Social Security to make a decision on your claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on your claim and could result in the loss of benefits. Although the information you furnish on this form is almost never used for any purpose other than making a determination on your disability claim, such information may be disclosed by the Social Security Administration as follows:

(1) To enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;

(2) To comply with Federal laws requiring the release of information from Social Security records (e.g., to the General Accounting Office and the Department of Veterans Affairs); and

(3) To facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

DAILY ACTIVITIES QUESTIONNAIRE

APPLICANT NAME: _____

Date: _____

Social Security Number: _____

THE ANSWERS TO THESE QUESTIONS WILL HELP US TO DETERMINE WHETHER YOUR CONDITION IS DISABLING WITHIN THE MEANING OF THE LAW. PLEASE EXPLAIN YOUR ANSWERS WHEREVER POSSIBLE BY GIVING DESCRIPTIONS AND EXAMPLES. IF YOU NEED MORE ROOM FOR YOUR ANSWERS, YOU MAY USE ADDITIONAL SHEETS. YOUR COOPERATION IS APPRECIATED.

GENERAL INFORMATION:

1. Describe your current living situation. For example:
Alone_____ With Family_____ Friends_____ Other _____

2. Do you provide any care or assistance for spouse, children, parents, pets or others?

If yes, please describe the care you provide.

What is your current height and weight?
Height_____ Weight _____

3. Please describe what you do on an average day.

4. How many hours per night do you usually sleep? _____

Do you usually take naps during the day?_____
If so, how often? _____

Do you take medication to sleep?_____ If yes, what do you take and how often do you take it?

Please list any other medications you are taking for your condition and how often you take them.

PERSONAL CARE

5. Do you require assistance with any of the following personal needs?

Yes	No	
_____	_____	Bathing
_____	_____	Showering
_____	_____	Dressing
_____	_____	Hair Care
_____	_____	Other

If yes, please explain.

6. How often do you eat during an average day? _____

How often do you cook? _____ Do you prepare your own meals?_____ If no, who does prepare your meals? _____

Please explain any changes in your eating or cooking habits that have occurred since you became ill?

HOUSEHOLD MAINTENANCE

7. Do you need assistance with the following household chores?

Yes	No	
_____	_____	Dusting
_____	_____	Laundry
_____	_____	Dishes
_____	_____	Vacuuming/Mopping
_____	_____	Yard Work/Gardening

If yes, please explain.

8. If you heat your home with wood, do you chop your own wood?

Yes_____ No_____

Do you carry the wood indoors?

Yes_____ No_____

9. Do you perform any maintenance on your own car, such as changing the oil or changing tires?

10. How many times per week do you do the following activities?

Grocery Shopping _____
Mall/Retail Shopping _____
Banking _____
Doctor Visits _____
Pay Bills _____

11. When you do go out, do you usually:
Drive_____ Walk_____ Ride bus_____ Ride with someone else_____

Do you have a valid driver's license?
Yes _____ No _____

RECREATION AND HOBBIES

12. How many hours per day do you participate in the following activities?

Hours	Activity
_____	Watching Television
_____	Listening to the radio
_____	Listening to records

13. Do you spend any time reading the following?

_____ Books
_____ Magazines
_____ Newspapers
_____ Educational Materials
_____ Other

Do you wear glasses when you read?
Yes _____No_____

14. Please list any other hobbies or crafts that you enjoy doing.

15. Please list outdoor activities that you enjoy participating in.

Do you do volunteer work?_____ If yes, what type and how often?

Please describe any changes in your hobbies or activities since your condition began.

SOCIAL

16. How often do you go out of your home?

Where do you usually go?

17. Approximately how often do you attend any of the following activities?

Movies _____
Sports Activities_____
Church _____
Clubs/Organizations _____

18. How many times per week do you visit with the following people?

Relatives _____
Friends _____
Neighbors _____

19. How often do you talk on the phone to the following people?

Relatives _____
Neighbors _____
Friends _____
Others _____

20. Please describe any changes in your social activities that have occurred since your condition began.

21. How does your condition prevent you from working?

22. Have you ever lost a job due to your condition?

23. Have you tried to work since you became ill? If yes, explain what happened.

GENERAL

1. We may need additional information about your condition. Please complete the following information for persons we may contact who know about your medical condition; e.g., friend, relative, rehab. counselor, social worker, landlord, etc. (Please do not list treating physicians or mental health workers).

Name _____
Relationship_____

Address _____
City_____ State _____Zip _____Phone_____
==========
Name _____
Relationship_____

Address _____
City_____ State _____Zip _____Phone_____

2. If you have worked in the last two years, please list any employers whom we may contact for further information about your condition.

Company Name _____

Address _____
City_____ State _____Zip_____ Phone_____

Supervisor_____ Dates worked_____
==========
Company Name _____

Address _____
City_____ State _____Zip_____ Phone_____

Supervisor_____ Dates worked_____

3. Did you need help completing this form? Yes/No._____ If yes, who helped you?
NAME _____

Relationship_____ Phone _____
PLEASE SIGN, DATE AND RETURN THIS FORM WITHIN 10 DAYS IN THE SELF ADDRESSED STAMPED ENVELOPE PROVIDED.

Signature: _____

DATE: _____